R590. Insurance, Administration.
R590-164. Uniform Health Billing Rule. ***(Effective 2-25-2013)***
R590-164-1. Authority.

This rule is promulgated by the Insurance Commissioner pursuant to Subsection 31A-22-614.5 which authorizes the commissioner to adopt uniform claim forms, billing codes, and compatible systems of electronic billing.

R590-164-2. Purpose.

The purpose of this rule is to designate uniform claim forms, billing codes and compatible electronic data interchange standards for use by health payers and providers.

R590-164-3. Applicability and Scope.

(1) This rule applies to health claims, health encounters, and electronic data interchange between payers and providers.

(2) Except as otherwise specifically provided, the requirements of this rule apply to payers and providers.

(3) This rule does not prohibit a payer from requesting additional information required to determine eligibility of the claim under the terms of the policy or certificate issued to the claimant.

(4) This rule does not prohibit a payer or provider from using alternative forms or procedures specified in a written contract between the payer and provider.

(5) This rule does not exempt a payer or provider from data reporting requirements under state or federal law or regulation.

R590-164-4. Definitions.

As used in this rule:

(1) Uniform Claim Forms are defined as:

(a) "UB-04" means the health insurance claim form maintained by NUBC for use by institutional care providers.

(b) "Form CMS 1500" means the health insurance claim form maintained by NUCC for use by health care providers.

(c) "J400" means the uniform dental claim form approved by the American Dental Association for use by dentists.

(d) "NCPDP" means the National Council for Prescription Drug Program's Claim Form or its electronic counterpart.

(2) Uniform Claim Codes are defined as:

(a) "ASA Codes" means the codes contained in the ASA Relative Value Guide developed and maintained by the American Society of Anesthesiologists to describe anesthesia services and related modifiers.

(b) "CDT Codes" means the current dental terminology prescribed by the American Dental Association.

(c) "CPT Codes" means the current physicians procedural terminology, published by the American Medical Association.

(d) “DRG Codes” means Diagnosis Related Group codes. DRG’s are universal grouping that are used to clarify the type of inpatient care received. The DRG code, along with a diagnosis code and the length of the inpatient stay, are used to determine payment and reimbursement for claims.

(e) "HCPCS" means HCFA's Common Procedure Coding System, a coding

system that describes products, supplies, procedures and health professional services and includes, the American Medical Association's (AMA's) Physician Current Procedural Terminology, codes, alphanumeric codes, and related modifiers. This includes:

(i) "HCPCS Level 1 Codes" which are the AMA's CPT codes and modifiers for professional services and procedures.

(ii) "HCPCS Level 2 Codes" which are national alphanumeric codes and modifiers for health care products and supplies, as well as some codes for professional services not included in the AMA's CPT codes.

(f) "ICDCM Codes" means the diagnosis and procedure codes in the International Classification of Diseases, clinical modifications published by the U.S. Department of Health and Human Services.

(g) "NDC" means the National Drug Codes of the Food and Drug Administration.

(h) "UB04 Rate Codes" means the code structure and instructions established for use by the National Uniform Billing Committee.

(3) "Electronic Data Interchange Standard" means the:

(a) ASC X12N standard format developed by the Accredited Standards Committee X12N Insurance Subcommittee of the American National Standards Institute and the ASC X12N implementation guides as modified by the Utah Health Information Network (UHIN) Standards Committee;

(b) other standards developed by the UHIN Standards Committee at the request of the commissioner; and

(c) as adopted by the commissioner by rule.

(4) "HPID" means Health Plan Identifier. HPID is the national unique health plan identifier assigned to identify individual health plans.

(5) "NPI" means National Provider Identifier. A NPI is a unique ten digit identification number required by HIPAA for all health care providers in th3e United States. Providers must use their NPI to identify themselves in all HIPAA transactions.

(6) "Payer" means an insurer or third party administrator that pays for, or reimburses for the costs of health care expense.

(7) "Provider" means any person, partnership, association, corporation or other facility or institution that renders or causes to be rendered health care or professional services, and officers, employees or agents of any of the above acting in the course and scope of their employment.

(8) "UHIN Standards Committee" means the Standards Committee of the Utah Health Information Network.

(9) "CMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services. CMS replaced HCFA.

(10) "HIPAA" means the federal Health Insurance Portability and Accountability Act.

(11) "NUBC" means the National Uniform Billing Committee.

(12) "NUCC" means the National Uniform Claim Committee.

R590-164-5. Paper Claim Transactions.

Payers shall accept and may require the applicable uniform claim forms completed with the uniform claim codes.

R590-164-6. Electronic Data Interchange Transactions.

(1) The commissioner shall use the UHIN Standards Committee to develop electronic data interchange standards for use by payers and providers transacting health insurance business electronically. In developing standards for the commissioner, the UHIN Standards Committee shall consult with national standard setting entities including but not limited to Centers for Medicare and Medicaid Services (CMS), the National Uniform Claim Form Committee, ASC X12, NCPDP, and the National Uniform Billing Committee.

(2) Standards developed and adopted by the UHIN Standards Committee shall not be required for use by payers and providers, until adopted by the commissioner by rule.

(3) Payers shall accept the applicable electronic data if transmitted in accordance with the adopted electronic data interchange standard. Payers may reject electronic data if not transmitted in accordance with the adopted electronic data interchange standard.

(4) The following HIPAA+ electronic data interchange standards developed and adopted by the UHIN Standards Committee and adopted by the commissioner are hereby incorporated by reference with this rule and are available for public inspection at the department during normal business hours or at—www.insurance.utah.gov.

(a) "Administrative Transaction Acknowledgements Standard v3.0." Purpose: To create a process for acknowledging all electronic transactions between trading partners based on the communication, syntax semantic and business process specifications.

(b) "Anesthesia Standard v3.0." Purpose: to standardize the transmission of anesthesia data for health care services. This standard does not alter any contractual agreement between providers and payers.

(c) "Benefits Enrollment and Maintenance Standard v3.0." Purpose: To detail the standard transactions for the transmission of health care benefits enrollment and maintenance.

(d) "CMS 1500 Paper Claim Form Box 17 and 17A Standard v3.1." Purpose: To establish a standard approach to reporting referring provider name and identifier number on the claim form. This standard also provides the cross walk to the ASCX12 837 Professional Claim version 005010x222A1.

(e) "CMS 1500 Paper Claim Form Standard v3.0." Purpose: To clearly describe the standard use of each Box, for print images, and its crosswalk to the HIPAA 837 005010X222A1 Professional implementation guide.

(f) "Claim Acknowledgement Standard v3.1." Purpose: To provide a standardized claim acknowledgement in response to a claim submission. This transaction is used to report on the status of a claim/encounter at the pre-adjudication processing stage, for example, before the payer is legally required to keep a history of the claim or encounter.

(g) "Claim Status Inquiry and Response Standard v3.1." Purpose: To detail the standard transactions for the transmission of health care claim status inquiries and response after January 1, 2012. The transaction is intended to allow the provider to reduce the need for claim follow-up and facilitate the correction of claims.

(h) "Coordination of Benefits Standard v3.0." Purpose: To

streamline the coordination of benefits process between payers and providers or payer to payers. The standard is to define the data to be exchanged for coordination of benefits and to increase effective communications.

(i) "Dental Claim Billing Standard v3.1." Purpose: To describe the standard use of each item number, for print images, and its crosswalk to the HIPAA 837 005010X0224A1 dental implementation guide.

(j) "Electronic Remittance Advice Standard v 3.4." Purpose: To detail the standard transaction for the reporting of transmission receipt and transaction or functional group X12 and implementation guide errors. This standard adopts the use of the ASC X12 999 transaction.

(k) "Eligibility Inquiry and Response Standard v3.1." Purpose: To detail the standard transactions for the transmission of health care eligibility inquiries and responses.

(l) "Health Care Claim Encounter Standard v3.2." Purpose: To detail the standard transactions for the transmission of health care claims and encounters and associated transactions.

(m) "Health Identification Card Standard v1.2." Purpose: To standardize the patient health identification card information. This identification card addresses the human-readable appearance and machine-readable information used by the healthcare industry to obtain eligibility.

(n) "Home Health Standard v3.0." Purpose: To provide a uniform standard of billing for home health care claims and encounters.

(o) "Implementation Acknowledgement For Health Care Insurance v3.2." Purpose: To detail the standard transaction for the reporting of transmission receipt and transaction or functional group X12 and implementation guide error. This standard adopts the use of the ASC X12 999 transaction.

(p) "Individual Name Standard v2.0." Purpose: To provide guidance for entering names into provider, payer or sponsor systems for patients, enrollees, as well as all other people associated with these records.

(q) "Medicaid Enrollment Implementation Guide v3.0." Purpose: This standard establishes the use of the ASC X12 834 enrollment transaction for Medicaid enrollments.

(r) "Metabolic Dietary Products Standard v3.0." Purpose: To provide a uniform standard for billing of metabolic dietary products for those providers and payers using the UB04, the CMS 1500, the NCPDP, or an electronic equivalent.

(s) "National Provider Identifier Standard v3.0." Purpose: To inform providers of the national provider identifier requirements and the usage within the transactions.

(t) "Pain Management Standard v3.0." Purpose: To provide a uniform method of submitting pain management claims, encounters, pre-authorizations, and notifications.

(u) "Patient Identification Number Standard v3.0." Purpose: To describe the standard for the patient identification number.

(v) "Premium Payment Standard v3.0." Purpose: To detail the standard transactions for the transmission of premium payments.

(w) "Prior Authorization/Referral Standard v3.0." Purpose: To provide general recommendations to payers and providers about

handling electronic prior authorization and referrals.

(x) "Required Unknown Values Standard v 3.0." Purpose: To provide guidance for the use of common data values that can be used within the HIPAA transactions when a required data element is not known by the provider, payer or sponsor for patients, enrollees, as well as all other people associated with these transactions. These data values should only be used when the data is truly not available or known. These values should not to be used to replace known data.

(y) "Telehealth Standard v3.0." Purpose: To provide a uniform standard of billing for health care claims and encounters delivered via telehealth.

(z) "Transparency Administration Performance Standard v 1.0," Purpose: To establish performance measures that report the average telephone answer time and claim turnaround time.

(aa) "Transparency Denial Standard v 1.1." Purpose: To establish performance measures that report the number and cost of an insurer's denied health claims and to provide guidance pertaining to the reporting method and timeline.

(bb) "UB04 Form Locator Elements Standard v3.0." Purpose: To clearly describe the use of each form locator in the UB04 claim billing form and its crosswalk to the HIPAA 837 005010X223A2 institutional implementation guide.

R590-164-7. Separability.

If any provision of this rule or the application to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of the provision to other persons or circumstances may not be affected.

KEY: insurance law
Date of Enactment or Last Substantive Amendment: February 25, 2013
Notice of Continuation: March 11, 2010
Authorizing, and Implemented or Interpreted Law: 31A-22-614.5